



## CLIENT INTAKE FORM

Graceful Transition, Honoring Healing & Growth  
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Date of first appointment: \_\_\_\_\_

Please take your time in providing the following information. The questions are designed to help me begin to understand you so that our time together can be as productive as possible. Depending on your life circumstances and current symptoms, some of these questions can be triggering. Please feel free to skip over any that feel intrusive at this time. You and I can take time during our first session to complete the questionnaire. All information provided is confidential.

Referred by:

- Medical Provider: \_\_\_\_\_
- Insurance Provider: \_\_\_\_\_
- My Website:
- Psychology Today
- Friend/Family: \_\_\_\_\_
- Other: \_\_\_\_\_

Have you previously received any type of mental health services?

- Yes
- No

If yes, which of the following:

- Psychotherapy
- Medication
- Outpatient
- Hospitalizations

Inpatient Hospitalization If yes, please provide: Name of provider or facility: \_\_\_\_\_

Location: \_\_\_\_\_

Dates of treatment: \_\_\_\_\_

Reason for treatment: \_\_\_\_\_

Briefly, what brings you in today?

When did your symptoms first start? Within the last:

- 30 days
- 6--12 months
- 2 years
- During adolescence
- During childhood

What areas of your life have been affected because of these symptoms?

Are you currently experiencing overwhelming sadness, grief or depression?

- Yes
- No

If yes, for approximately how long? \_\_\_\_\_

Are you currently experiencing anxiety, panic attacks or have any phobias?

- Yes
- No

If yes, when did you begin experiencing this? \_\_\_\_\_

Please describe any major losses or traumas you have experienced:

What significant life changes or stressful events have you experienced recently?

What would you like to accomplish out of your time in therapy?

### **Family History**

Where were you born? \_\_\_\_\_

Where did you grow up? \_\_\_\_\_

- City
- Suburbs
- Country

Please list your parents and siblings. Please use additional space on the back if needed.

Name	Age	Relationship	Where do they live now?	If deceased, age and cause of death

Who did you live with while growing up? \_\_\_\_\_

Mother's occupation: \_\_\_\_\_

Father's occupation: \_\_\_\_\_

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.). See next page.

Condition	Please Circle	List Family Member(s)
Alcohol/Substance Abuse	Yes/No	
Anxiety	Yes/No	
Depression	Yes/No	
Intimate Partner Violence	Yes/No	
Sexual Abuse	Yes/No	
Eating Disorders	Yes/No	
Obesity	Yes/No	
Obsessive Compulsive Disorder	Yes/No	
Schizophrenia	Yes/No	
Suicide Attempts	Yes/No	

Other diagnosed mental health condition? yes/no :

Please describe: \_\_\_\_\_

**Marital Status:**

- Never Married
- Domestic Partner
- Married
- Separated
- Divorced -- For how long?
- Widowed: Please provide your partners name and year deceased: \_\_\_\_\_  
\_\_\_\_\_

If married, how long have you been married for and what is your partners name:

\_\_\_\_\_

On a scale of 1-10 (best), how would you rate your relationship? \_\_\_\_\_

Are you currently in a romantic relationship?

- Yes -- How long? \_\_\_\_\_
- No

On a scale of 1-10 (best), how would you rate your relationship? \_\_\_\_\_

Please list any children, their names, and ages:

Name	Age	Relationship	Name of other parent(s)	If deceased, age & cause of death

### Physical Health

Please list any medications, herbs, or supplements. Be sure to include the condition, as some medications are prescribed for off-label use. Continue on the back if needed, or provide a separate list.

If you have a complicated medical profile, please supply supporting documentation to be able to facilitate a comprehensive understanding of your health.

Medication/Supplement Dosage Condition Date Began/Stopped Prescribing provider and contact information:

Name: \_\_\_\_\_

Specialty: \_\_\_\_\_

Facility: \_\_\_\_\_

Phone, email, or Fax:  
\_\_\_\_\_

How would you rate your current physical health?

- Poor
- Unsatisfactory
- Satisfactory
- Good
- Very Good

Please list any specific health problems you are currently experiencing:

How would you rate your current sleeping habits?

- Poor
- Unsatisfactory
- Satisfactory
- Good
- Very Good

If you are having problems, in which phase of sleep are you experiencing issues?

- Falling asleep
- Staying asleep
- Awakening early
- Sleep apnea

Please list any other specific sleep problems you are currently experiencing:

How many times per week do you generally exercise? \_\_\_\_\_

What types of exercise do you participate in:

Are you currently experiencing any chronic pain?

- No
- Yes

If yes, please describe:

Please describe current use of alcohol, cigarettes, and/or recreational drugs:

Please describe previous use of alcohol, cigarettes, and/or recreational drugs:

### **Additional Information**

What do you enjoy about your work (full-time homemaker included)?

If retired, what did you enjoy about your work?

What do you find particularly stressful about your current or previous work?

What do you enjoy doing in your free time?

What do you do to relax?

Do you consider yourself to be spiritual or religious?

If yes, please describe your faith or belief:

In what areas would you like to increase your skills?

What do you consider to be some of your strengths?